FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032276

Facility Name: BOULEVARD CARE CENTER

Address: 3405 S. MICHIGAN AVE. (Number) CHICAGO (City) 60616 (Zip Code)

County: COOK

Telephone Number: (847) 329-1555 **Fax #** (847) 329-9555

IDPA ID Number: 36-3507813

Date of Initial License for Current Owners: 05/01/87

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHERWIN I. RAY
(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	155	Skilled (SNF)	155	56,730	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,730	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			3,976	3,976	8
9	SNF/PED					9
10	ICF	46,111	734		46,845	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	46,111	734	3,976	50,821	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.58%

D. How many bed-hold days during this year were paid by Public Aid?
351 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 3,976

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	159,656	21,062	15,217	195,935		195,935	(809)	195,126			1
2	Food Purchase		191,925		191,925	(18,611)	173,314	(317)	172,997			2
3	Housekeeping	118,058	22,493		140,551		140,551		140,551			3
4	Laundry	50,315	14,798		65,113		65,113		65,113			4
5	Heat and Other Utilities			112,376	112,376		112,376	704	113,080			5
6	Maintenance	79,599	24,372	36,409	140,380		140,380	8,111	148,491			6
7	Other (specify):*			13,397	13,397		13,397	369	13,766			7
8	**TOTAL General Services**	407,628	274,650	177,399	859,677	(18,611)	841,066	8,058	849,124			8
	B. Health Care and Programs											
9	Medical Director			2,400	2,400		2,400		2,400			9
10	Nursing and Medical Records	1,277,937	49,888	127,240	1,455,065		1,455,065	(97,927)	1,357,138			10
10a	Therapy	82,938	4,714	65,750	153,402		153,402	(53,726)	99,676			10a
11	Activities	57,522	6,350	11,516	75,388		75,388	(9,248)	66,140			11
12	Social Services	111,640			111,640		111,640		111,640			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,530,037	60,952	206,906	1,797,895		1,797,895	(160,901)	1,636,994			16
	C. General Administration											
17	Administrative	124,297		198,000	322,297		322,297	(71,420)	250,877			17
18	Directors Fees											18
19	Professional Services			286,478	286,478		286,478	(225,989)	60,489			19
20	Dues, Fees, Subscriptions & Promotions			15,032	15,032		15,032	(1,499)	13,533			20
21	Clerical & General Office Expenses	129,328	14,373	135,949	279,650		279,650	(19,256)	260,394			21
22	Employee Benefits & Payroll Taxes			354,472	354,472	18,611	373,083		373,083			22
23	Inservice Training & Education			600	600		600	1,302	1,902			23
24	Travel and Seminar							429	429			24
25	Other Admin. Staff Transportation			332	332		332	4,325	4,657			25
26	Insurance-Prop.Liab.Malpractice			203,282	203,282		203,282	2,721	206,003			26
27	Other (specify):*							47,980	47,980			27
28	**TOTAL General Administration**	253,625	14,373	1,194,145	1,462,143	18,611	1,480,754	(261,407)	1,219,347			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,191,290	349,975	1,578,450	4,119,715		4,119,715	(414,250)	3,705,465			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: BOULEVARD CARE CENTER **#0032276** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	12,494	
	REPAIRS & MAINTENANCE		2,723	
			0	15,217
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		41,649	
	ELECTRICITY		45,488	
	WATER		25,239	
	CABLE TV - LOBBY			
			0	112,376
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		3,023	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		10,972	
	ELEVATOR MAINTENANCE & REPAIR		4,915	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		4,980	
	FIRE SERVICE		12,519	
			0	
			0	
			0	36,409
7	**OTHER**			
	SCAVENGER		13,397	
	SECURITY SERVICE		0	13,397
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	2,400	2,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	1,760	
	PHARMACY CONSULTANT	XVIII B 39-2	480	
	UTILIZATION REVIEW FEES	XVIII B __-2	50,000	
	PHYSICIANS	XVIII B __-2	50,000	
	PSYCHIATRIC	XVIII B __-2	25,000	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	127,240
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		7,101	
	SPEECH THERAPY SERVICES		392	
	OCCUPATIONAL THERAPY SERVICES		837	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	5,400	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,400	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	THERAPY CONTRACT SERVICES	XVIII B 43-2	46,620	65,750
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		9,248	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,268	
			0	11,516
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	0
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number BOULEVARD CARE CENTER #0032276 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	198,000	198,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	24,443	
	ADMINISTRATIVE CONSULTANTS	XIX C	218,000	
	PROFESSIONAL FEES	XIX C	44,035	
			0	286,478
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,361	
	EMPLOYEE WANT ADS	XIX F	1,932	
	CONTRIBUTIONS	VI 20 XIX F	50	
	DUES & SUBSCRIPTIONS	XIX F	1,024	
	LICENSES & PERMITS	XIX F	7,400	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	265	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	15,032
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		0	
	EQUIPMENT REPAIR & MAINTENANCE		5,007	
	OUTSIDE CLERICAL SERVICES		93,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	13,444	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		23,443	
	MESSENGER SERVICE		1,055	
			0	135,949

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	165,207	
	UNEMPLOYMENT COMPENSATION	XIX D	33,840	
	WORKERS COMPENSATION INSURANCI	XIX D	38,397	
	HOSPITALIZATION INSURANCE	XIX D	91,125	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,500	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	20,609	
	CHICAGO HEAD TAX	XIX D	3,794	354,472
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		600	600
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		332	332
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		203,282	203,282
27	**OTHER**			
	BAD DEBTS	VI 24	0	
				0

GRAND TOTAL COLUMN 3 OTHER 1,578,450

BOULEVARD CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	191,925
LESS SALES TAX	(317)
NET FOOD	191,608
TOTAL PATIENT CENSUS	50,821
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	152463
ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	366
TOTAL EMPLOYEE MEALS	16470

PATIENT MEALS	152463
ADD EMPLOYEE MEALS	16470
TOTAL MEALS/YEAR	168933
NET FOOD	191608
DIVIDE TOTAL MEALS/YEAR	168933
COST PER MEAL	1.13
TIME EMPLOYEE MEALS	16470
EMPLOYEE MEAL RECLASSIFICATION	18611

Facility Name & ID Number BOULEVARD CARE CENTER #0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			65,146	65,146		65,146	120,389	185,535			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			79,960	79,960		79,960	419,301	499,261			32
33	Real Estate Taxes			211,771	211,771		211,771		211,771			33
34	Rent-Facility & Grounds			516,012	516,012		516,012	(509,606)	6,406			34
35	Rent-Equipment & Vehicles			63,206	63,206		63,206	(31,062)	32,144			35
36	Other (specify):*											36
37	**TOTAL Ownership**			936,095	936,095		936,095	(978)	935,117			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		103,361	313,166	416,527		416,527	(263,939)	152,588			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			85,096	85,096		85,096		85,096			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		103,361	398,262	501,623		501,623	(263,939)	237,684			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,191,290	453,336	2,912,807	5,557,433		5,557,433	(679,167)	4,878,266			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(9,248)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,300)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(317)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(13,444)	21		18
19	Entertainment		20		19
20	Contributions	(50)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(4,361)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(265)	20		28
29	Other-Attach Schedule SEE PAGE 5 A	(20,692)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (57,677)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(621,490)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (621,490)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (679,167)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Page 5A

BOULEVARD CARE CENTER

ID# 0032276

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 938	6	1
2	MARKETING SALARIES	(21,630)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(20,692)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	(809)	0	0	0	0	0	0	0	0	0	(809)	1
2	Food Purchase	(317)	0	0	0	0	0	0	0	0	0	0	(317)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	704	0	0	0	0	0	0	0	0	0	704	5
6	Maintenance	938	7,173	0	0	0	0	0	0	0	0	0	8,111	6
7	Other (specify):*	0	0	369	0	0	0	0	0	0	0	0	369	7
8	**TOTAL General Services**	621	7,068	369	0	0	0	0	0	0	0	0	8,058	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	(125,000)	27,073	0	0	0	0	0	0	0	0	(97,927)	10
10a	Therapy	0	0	3,576	(57,302)	0	0	0	0	0	0	0	(53,726)	10a
11	Activities	(9,248)	0	0	0	0	0	0	0	0	0	0	(9,248)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(9,248)	(125,000)	30,649	(57,302)	0	0	0	0	0	0	0	(160,901)	16
	C. General Administration													
17	Administrative	0	(144,000)	72,580	0	0	0	0	0	0	0	0	(71,420)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(230,000)	4,011	0	0	0	0	0	0	0	0	(225,989)	19
20	Fees, Subscriptions & Promotions	(4,676)	0	3,177	0	0	0	0	0	0	0	0	(1,499)	20
21	Clerical & General Office Expenses	(35,074)	(93,000)	108,818	0	0	0	0	0	0	0	0	(19,256)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,302	0	0	0	0	0	0	0	0	1,302	23
24	Travel and Seminar	0	0	429	0	0	0	0	0	0	0	0	429	24
25	Other Admin. Staff Transportation	0	0	4,325	0	0	0	0	0	0	0	0	4,325	25
26	Insurance-Prop.Liab.Malpractice	0	0	2,721	0	0	0	0	0	0	0	0	2,721	26
27	Other (specify):*	0	0	47,980	0	0	0	0	0	0	0	0	47,980	27
28	**TOTAL General Administration**	(39,750)	(467,000)	245,343	0	0	0	0	0	0	0	0	(261,407)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(48,377)	(584,932)	276,361	(57,302)	0	0	0	0	0	0	0	(414,250)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(9,300)	0	10,443	119,246	0	0	0	0	0	0	0	120,389	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	29,959	389,342	0	0	0	0	0	0	0	419,301	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	6,406	(516,012)	0	0	0	0	0	0	0	(509,606)	34
35	Rent-Equipment & Vehicles	0	0	6,950	(38,012)	0	0	0	0	0	0	0	(31,062)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(9,300)	0	53,758	(45,436)	0	0	0	0	0	0	0	(978)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	(263,939)	0	0	0	0	0	0	0	(263,939)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	(263,939)	0	0	0	0	0	0	0	(263,939)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(57,677)	(584,932)	330,119	(366,677)	0	0	0	0	0	0	0	(679,167)	45

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				CAREPLUS MGMT.	SKOKIE	MGMT/CLERICAL
				CAREPLUS REHAB	SKOKIE	THERAPY
SEE ATTACHED SCHEDULE						
				BOULEVARD		
				PROPERTY, LLC	NILES	REAL ESTATE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY CONSULT. FEES	$ 3,850	CAREPLUS MANAGEMENT, INC.		$	$ (3,850)	1
2	V	10	MEDICARE CONSULT. FEES	50,000				(50,000)	2
3	V	10	PA CONSULTANT FEES	50,000				(50,000)	3
4	V	10	PSYCHIATRIC CONS. FEE	25,000				(25,000)	4
5	V	17	MANAGEMENT FEES	144,000				(144,000)	5
6	V	19	ADMIN. CONSULT. FEES	218,000				(218,000)	6
7	V	19	DATA PROCESS FEES	12,000				(12,000)	7
8	V	21	CLERICAL FEES	93,000				(93,000)	8
9	V								9
10	V	1	DIETARY SALARIES				3,041	3,041	10
11	V	5	UTILITIES				704	704	11
12	V	6	MAINT AND REPAIR				25	25	12
13	V	6	MAINTENANCE SALARIES				7,148	7,148	13
14	Total			$ 595,850			$ 10,918	$ * (584,932)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	SECURITY	$	CAREPLUS MGMT. INC.		$ 369	$ 369	15
16	V	10	NURSING SALARIES				27,073	27,073	16
17	V	10A	THERAPY SALARIES				3,576	3,576	17
18	V	17	ADMIN. SALARIES				72,580	72,580	18
19	V	19	PROFESSIONAL FEES				4,011	4,011	19
20	V	20	ADVERTISING				3,177	3,177	20
21	V	21	TOTAL OFFICE				35,200	35,200	21
22	V	21	CLERICAL SALARIES				73,618	73,618	22
23	V	23	SEMINARS				1,302	1,302	23
24	V	24	TRAVEL				429	429	24
25	V	25	TRANSPORTATION				4,325	4,325	25
26	V	26	INSURANCE				2,721	2,721	26
27	V	27	EMPLOYEE BENEFITS				47,980	47,980	27
28	V	30	DEPRECIATION (SL)				10,443	10,443	28
29	V	32	INTEREST				29,959	29,959	29
30	V	34	OFFICE RENT				6,406	6,406	30
31	V	35	EQUIPMENT RENT				6,950	6,950	31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 330,119	$ * 330,119	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY SERVICES	$ 63,347	CAREPLUS REHABILITATIVE SERVICES		$ 6,045	$ (57,302)	15
16	V	39	ANCILLARY THERAPY	315,567			51,628	(263,939)	16
17	V	35	EQUIPMENT RENTAL	38,012				(38,012)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V	34	RENT	516,012	BOULEVARD PROPERTY, LLC			(516,012)	26
27	V	30	SL DEPRECIATION				119,246	119,246	27
28	V	32	INTEREST				389,342	389,342	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 932,938			$ 566,261	$ * (366,677)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATION:								$		1
2	SHERWIN RAY	PRESIDENT	ADMINISTRAT.	40.32	SEE ATTACHED	5.4		SALARY	16,623	17-7	2
3			FINANCE		SCHEDULE						3
4			BANKING								4
5	JAKOB BAKST	DIR OPERATIONS	FINANCE	1.61		5.4		SALARY	16,623	17-7	5
6											6
7											7
8											8
9	HUNTER MGMT	ERIC ROTHNER	MGMT	32.26				MGMT FEES	54,000	17-3	9
10											10
11											11
12											12
13								TOTAL	$ 87,246		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT, INC.
Street Address: 8320 SKOKIE BLVD.
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 329-1555
Fax Number: (847) 329-9555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	451,049	9	$ 26,990	$	50,821	$ 3,041	1
2	5	UTILITIES	CENSUS DAYS	565,586	13	7,834		50,821	704	2
3	6	MAINT AND REPAIR	CENSUS DAYS	565,586	13	275		50,821	25	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	565,586	13	79,548		50,821	7,148	4
5	7	SECURITY	CENSUS DAYS	565,586	13	4,112		50,821	369	5
6	10	NURSING SALARIES	CENSUS DAYS	565,586	13	301,295		50,821	27,073	6
7	10A	THERAPY SALARIES	CENSUS DAYS	565,586	13	39,798		50,821	3,576	7
8	17	ADMIN. SALARIES	CENSUS DAYS	565,586	13	807,745		50,821	72,580	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	565,586	13	44,637		50,821	4,011	9
10	20	ADVERTISING	CENSUS DAYS	565,586	13	35,362		50,821	3,177	10
11	21	TOTAL OFFICE	CENSUS DAYS	565,586	13	391,736		50,821	35,200	11
12	21	CLERICAL SALARIES	CENSUS DAYS	565,586	13	819,289		50,821	73,618	12
13	23	SEMINARS	CENSUS DAYS	565,586	13	14,490		50,821	1,302	13
14	24	TRAVEL	CENSUS DAYS	565,586	13	4,769		50,821	429	14
15	25	TRANSPORTATION	CENSUS DAYS	565,586	13	48,136		50,821	4,325	15
16	26	INSURANCE	CENSUS DAYS	565,586	13	30,286		50,821	2,721	16
17	27	EMPLOYEE BENEFITS	CENSUS DAYS	565,586	13	533,964		50,821	47,980	17
18	30	DEPRECIATION (SL)	CENSUS DAYS	565,586	13	116,219		50,821	10,443	18
19	32	INTEREST	CENSUS DAYS	565,586	13	333,416		50,821	29,959	19
20	34	OFFICE RENT	CENSUS DAYS	565,586	13	71,288		50,821	6,406	20
21	35	EQUIPMENT RENT	CENSUS DAYS	565,586	13	77,344		50,821	6,950	21
22										22
23										23
24										24
25	TOTALS					$ 3,788,533	$		$ 341,037	25

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY: BOULEVARD PROPERTY, LLC						$	$			$	1
2	PACIFIC MUTUAL		X	MORTGAGE	$38,703.00	12/95	4,657,452	4,175,523	01/08	0.0888	369,465	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER 12 YEARS		116,756	28,471	01/08		9,730	3
4	CIB BANK LOAN COSTS		X	CAPITAL IMPROVEMENT	$4,052.62	01/04	360,000	135,371	01/09	PRIME+	9,367	4
5	LOAN COSTS		X	LOAN COSTS	W/O OVER 5 YEARS		1,800		W/O BAL		780	5
	Working Capital											
6	CAREPLUS MGMT	X		WORKING CAPITAL	DEMAND	04/95	450,000			PRIME+	76,274	6
7	A.I. IMPERIAL CREDIT		X	INSURANCE FINANCING							3,686	7
8	MGMT ALLOCATION										29,959	8
9	TOTAL Facility Related				$42,755.62		$ 5,586,008	$ 4,339,365			$ 499,261	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,586,008	$ 4,339,365			$ 499,261	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 162,903	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 186,405	2
3. Under or (over) accrual (line 2 minus line 1).		$ 23,502	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 188,269	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 211,771	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	184,219	8
	2000	155,459	9
	2001	159,502	10
	2002	161,290	11
	2003	186,405	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME BOULEVARD CARE CENTER COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0032276

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-34-119-001-0000	NURSING HOME	$ 55,325.41	$ 55,325.41
2.	17-34-119-002-0000	NURSING HOME	$ 9,319.94	$ 9,319.94
3.	17-34-119-003-0000	NURSING HOME	$ 92,308.85	$ 92,308.85
4.	17-34-119-004-0000	NURSING HOME	$ 9,021.83	$ 9,021.83
5.	17-34-119-005-0000	NURSING HOME	$ 10,214.64	$ 10,214.64
6.	17-34-119-006-0000	NURSING HOME	$ 10,214.64	$ 10,214.64
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 186,405.31	$ 186,405.31

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,293 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	51,000	1995	$ 100,000	1
2					2
3	TOTALS	51,000		$ 100,000	3

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155		1995	1971	$ 4,046,250	$ 103,746	39	$ 103,746	$	$ 1,024,633	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LIGHT FIXTURES			1987	3,077		20	154	154	2,701	9
10	LEASEHOLD IMPROVEMENTS			1987	1,159	37	15	77	40	1,279	10
11	FIRE ALARM SERVICE			1988	10,046	319	20	502	183	8,408	11
12	ROOFING			1989	2,000	63	20	100	37	1,642	12
13	SEWER REPAIR			1989	3,250	104	15	217	113	3,273	13
14	ROOFING & AWNING			1990	7,780	247	20	389	142	5,738	14
15	LEASEHOLD IMPROVEMENTS			1991	16,578	575	20	829	254	11,151	15
16	LEASEHOLD IMPROVEMENTS			1992	1,800	120	15	120		1,500	16
17	LEASEHOLD IMPROVEMENTS			1992	19,702	625	31.5	625		7,808	17
18	LEASEHOLD IMPROVEMENTS			1993	25,871	736	31.5	821	85	9,357	18
19	LEASEHOLD IMPROVEMENTS			1994	8,666	222	39	222		2,239	19
20	LEASEHOLD IMPROVEMENTS			1994	4,690		20	235	235	2,467	20
21	ROOF REPAIRS			1995	1,500	38	39	38		376	21
22	ELEVATOR REPAIR / DOOR			1995	5,575	143	39	143		1,293	22
23	LANDSCAPING / FENCE REPAIR			1995	5,195	346	15	346		3,294	23
24	SUMP PUMP			1996	2,840	73	39	73		636	24
25	WALK-IN FREEZER REPAIR			1996	3,187	81	39	81		699	25
26	ROOF REPAIRS			1996	8,735	224	39	224		1,876	26
27	SECURITY SYSTEM			1996	1,035	27	39	27		217	27
28	ELEVATOR REPAIR			1997	6,017	154	39	154		1,185	28
29	WINDOWS			1997	1,170	30	39	30		229	29
30	CARPETING			1998	2,187	56	39	56		376	30
31	FIRE DAMPERS			1998	8,240	212	39	212		1,303	31
32	SEWER REPAIRS			1998	2,704	69	39	69		428	32
33	IRON FENCE			1998	4,684	312	15	312		2,028	33
34	INSTALL PIPE			1999	6,043	155	39	155		898	34
35	FLOORING-RESIDENT BATHROOMS			2000	23,773	865	27.5	865		4,142	35
36	ALARM SYSTEM			2000	94,362	3,431	27.5	3,431		16,441	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	SMALL SERVICE ELEVATOR	2000	$ 64,585	$ 2,348	27.5	$ 2,348	$	$ 9,686	37
38	AWNING	2000	2,700	98	27.5	98		404	38
39	INSTALL NEW ROOF SYSTEM	2000	49,600	1,804	27.5	1,803	(1)	7,438	39
40	REPAIR SMALL & LARGE PASSENGER ELEVATORS	2001	5,786	210	27.5	210		797	40
41	INSTALL NEW STEAM TABLE	2001	4,147	151	27.5	151		572	41
42	EJECTOR PUMP	2001	2,878	105	27.5	105		389	42
43	INTERIOR ENTRANCE-INSTALL ALUMINUM DOOR	2001	2,748	100	27.5	100		354	43
44	RESIDENT ROOMS-CLOSETS	2001	20,078	730	27.5	730		2,525	44
45	EXISTING SPRINKLER SYSTEM-PLACARD	2001	3,600	131	27.5	131		442	45
46	INSTALL CHAIN FENCE	2001	1,400	108	15	93	(15)	452	46
47	FIRE ALARM REPAIR	2001	6,392	232	27.5	232		744	47
48	REPLACEMENT CARPET FOR 5 OFFICES	2001	3,294	379	20	165	(214)	660	48
49	REPLACEMENT OF WINDOW	2001	2,880	105	27.5	105		328	49
50	INSTALL BASEBOARD COVERS, WALK-IN COOLER	2001	3,314	382	20	166	(216)	664	50
51	NEW WALL, FLOORING-ELEVATORS	2001	4,506	519	20	225	(294)	900	51
52	FLOORING-1ST, 2ND, 3RD FL CORR/DAYROOM/NURSES ST	2002	49,673	1,806	27.5	1,806		5,200	52
53	NEW WINDOW TREATMENTS, DRAPERY PANELS	2002	6,807	915	20	340	(575)	1,020	53
54	2ND & 3RD FLOOR-WOOD BASEBOARD	2002	3,367	453	20	168	(285)	504	54
55	WALLCOVERING-LOBBY 1ST, 2ND & 3RD FLOOR	2002	31,043	1,129	27.5	1,129		2,587	55
56	INSTALL NEW SUSPENDED CEILING & LIGHTING	2002	46,843	1,703	27.5	1,703		3,619	56
57	ELECTRICAL WORK-1ST, 2ND AND 3RD FLOOR	2002	9,105	331	27.5	331		676	57
58	ELEVATOR-INSTALL OF CONTROLLER, CAR & HALL ST.	2003	99,988	3,636	27.5	3,636		7,121	58
59	REMODELING OF SHOWER & TUB ROOMS	2003	35,363	1,286	27.5	1,286		2,411	59
60	2ND&3RD FL -HANDRAILS&BUMPERS/1ST FL NURSE STAT	2003	63,426	2,306	27.5	2,306		2,804	60
61	SOCIAL SERVICES-INSTALL NEW STEEL FRAME	2003	2,469	90	27.5	90		146	61
62	ELECTRICAL WORK FOR ELEVATOR	2003	5,562	202	27.5	202		329	62
63	REMODELING OF THE SHOWER, TUB, RESIDENT ROOMS	2004	109,477	3,152	27.5	3,152		3,152	63
64	REPAIR MASONRY ABOVE TOP FLOOR WINDOWS	2004	7,600	104	27.5	104		104	64
65	INSTALLED EXHAUST FOR OXYGEN ROOM	2004	2,150	16	27.5	16		16	65
66	.								66
67									67
68									68
69	CAREPLUS MGMT INC: LEASEHOLD IMPROVEMENTS			106		106			69
70	TOTAL (lines 4 thru 69)		$ 4,978,897	$ 137,647		$ 137,290	$ (357)	$ 1,173,661	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 209,122	$ 12,511	$ 20,733	$ 8,222		$ 116,910	71
72	Current Year Purchases	31,400	18,840	1,675	(17,165)		1,675	72
73	Fully Depreciated Assets	82,888					82,888	73
74	RELATED PARTY ALLOCATION		25,837	25,837				74
75	TOTALS	$ 323,410	$ 57,188	$ 48,245	$ (8,943)		$ 201,473	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,402,307	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 194,835	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 185,535	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (9,300)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,375,134	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 63,206 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 141,112	$		$ 141,112	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			2,138			2,138	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			169,916			169,916	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts			102,378			102,378	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): RENTALS	39-2 39-2					695 288		695 288	13
14	TOTAL			$		$ 415,544	$ 983		$ 416,527	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (134,697)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 111,247)	1,915,113		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	53,079		6
7	Other Prepaid Expenses	15,126		7
8	Accounts Receivable (owners or related parties)	119,556		8
9	Other(specify): Real Estate Tax Escrow	132,014		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,100,191	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	924,880		15
16	Equipment, at Historical Cost	323,410		16
17	Accumulated Depreciation (book methods)	(440,785)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	(233,301)		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 574,204	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,674,395	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 549,932	$	26
27	Officer's Accounts Payable	1,162,362		27
28	Accounts Payable-Patient Deposits	15,552		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	77,941		30
31	Accrued Taxes Payable (excluding real estate taxes)	14,267		31
32	Accrued Real Estate Taxes(Sch.IX-B)	188,269		32
33	Accrued Interest Payable	4,469		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,012,792	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,012,792	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 661,603	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,674,395	$	48

*(See instructions.)

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,387,972	1
2	Restatements (describe):		2
3	POST CLOSING ADJ	(866,284)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 521,688	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	139,915	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 139,915	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 661,603	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,695,821	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,695,821	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	1,527	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,527	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,697,348	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	859,677	31
32	Health Care	1,797,895	32
33	General Administration	1,462,143	33
	B. Capital Expense		
34	Ownership	936,095	34
	C. Ancillary Expense		
35	Special Cost Centers	416,527	35
36	Provider Participation Fee	85,096	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 5,557,433	40
41	**Income before Income Taxes (line 30 minus line 40)****	139,915	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 139,915	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,760	1,811	$ 50,049	$ 27.64	1
2	Assistant Director of Nursing	1,655	1,722	45,106	26.19	2
3	Registered Nurses	422	422	9,228	21.87	3
4	Licensed Practical Nurses	29,955	30,794	588,508	19.11	4
5	Nurse Aides & Orderlies	58,439	63,279	565,571	8.94	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,543	7,880	82,938	10.53	8
9	Activity Director	2,012	2,094	22,954	10.96	9
10	Activity Assistants	4,691	4,789	34,568	7.22	10
11	Social Service Workers	6,100	6,454	111,640	17.30	11
12	Dietician					12
13	Food Service Supervisor	1,954	2,074	30,488	14.70	13
14	Head Cook	4,962	5,341	40,812	7.64	14
15	Cook Helpers/Assistants	11,992	12,637	88,356	6.99	15
16	Dishwashers					16
17	Maintenance Workers	8,299	8,690	79,599	9.16	17
18	Housekeepers	14,738	15,720	118,058	7.51	18
19	Laundry	5,176	5,780	50,315	8.71	19
20	Administrator	4,086	4,448	124,297	27.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,829	7,290	107,698	14.77	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,899	1,948	19,475	10.00	31
32	Other Health Care(specify)					32
33	Other(specify) Dir.of Marketing	799	813	21,630	26.61	33
34	TOTAL (lines 1 - 33)	172,311	183,986	$ 2,191,290 *	$ 11.91	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 12,494	1-3	35
36	Medical Director	O	2,400	9-3	36
37	Medical Records Consultant	N	1,760	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	480	10-3	39
40	Physical Therapy Consultant	L	5,400	10a-3	40
41	Occupational Therapy Consultant	Y	5,400	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	2,268	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify) PSYCHIATRIC	S	25,000	10-3	46
47	UTILIZATION REVIEW FEES		50,000	10-3	47
48	PHYSICIANS		50,000	10-3	48
49	TOTAL (lines 35 - 48)		$ 155,202		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
KEVIN MEALS	ADMIN	0	$ 65,295
CYNTHIA STAIN	ASST ADMIN	0	59,002
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 124,297

B. Administrative - Other

Description		Amount
CAREPLUS MANAGEMENT, INC	MANAGEMENT FEES	$ 144,000
HUNTER MANAGEMENT	MANAGEMENT FEES	54,000
TOTAL (agree to Schedule V, line 17, col. 3)		$ 198,000
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		286,478
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 286,478

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 38,397
Unemployment Compensation Insurance		33,840
FICA Taxes		165,207
Employee Health Insurance		91,125
Employee Meals		18,611
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		1,500
EMPLOYEE PHYSICAL EXAMS		0
PENSION/PROFIT SHARING PLANS		20,609
CHICAGO HEAD TAX		3,794
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 373,083

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 5,100
Advertising: Employee Recruitment	1,932
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	4,626
TRUST/FRANCHISE/CONTRIB/ETC	50
LICENSES & PERMITS	2,300
DUES & SUBSCRIPTIONS	1,024
MGMT CO ALLOCATION	3,177
TRUST/FRANCHISE/CONTRIB/ETC	(50)
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,361)
Yellow page advertising	(265)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,533

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	0
MGMT CO ALLOCATION	429
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 429

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	2001	$ 1,552	3 YRS	$ 258	$ 518	$ 518	$ 258	$	$	$	$	$
2	PAINTING/DECORATIN	2002	2,039	3 YRS		340	680	680	340				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
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14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,591		$ 258	$ 858	$ 1,198	$ 938	$ 340	$	$	$	$

Facility Name & ID Number BOULEVARD CARE CENTER # 0032276 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **NO**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **NO**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **905** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **85,096**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **18,611** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees